Appletree Orthodontics
Specialists in Orthodontics for Children and Adults
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Diplomates of the American Board of Orthodontics
Members American Association of Orthodontists

We are pleased that you called our office for your orthodontic treatment. Your appointment will take approximately one hour. Please fill out this medical/dental History Questionnaire in order to help us with your diagnosis and treatment planning. *Please complete the entire questionnaire and bring it with you to your appointment or email back to braces@appletreeortho.com, thank you.*

Health History Questionnaire

Please provide us with the following information about this patient:

Patient's Last Name:_____, 1st_____ MI_____ Sex: ❑ M ❑ F Birth Date: _____

Patient's Address: _____

Work Phone:_____ Home Phone: _____ Cell Phone: _____

School/Employer:_____ Grade/Dept._____ E-mail address: _____

If a child, Parent's Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Widowed ❑ Divorced

Father/Husband:_____ Work Phone:_____ Home Phone: _____

Address:_____ Cell Phone: _____

Employer:_____ Occupation: _____

Mother/Wife:_____ Work Phone:_____ Home Phone: _____

Address:_____ Cell Phone: _____

Employer:_____ Occupation: _____

Whom may we thank for referring you to our office?_____

In case we can't reach you, whom can we contact?

Person's Name:_____ Relationship:_____ Phone: _____

Financially Responsible Person: {if the patient, skip down to * and complete the rest of the data}

Last Name:_____, 1st_____ MI_____

Relation to Pt: _____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Address:_____ Apt. # _____

Employer: _____ Occupation:_____

*INSURANCE

Primary INS Co.: _____ Group/Plan #_____ ID# _____

Name of Insured:_____ Birth Date (_____-___-_____) SSN: _____

Preferred Method of Contact: ❑ Home Phone ❑ Cell Phone ❑ Work Phone ❑ Email ❑ Text

MEDICAL HISTORY

Name of Family Physician: _____ Date of last visit to physician: _____

Are there any medical specialists you see regularly? Specialty: _____

When was the last time you had a complete physical exam? Date: _____ Examining doctor: _____

- Has this patient been advised by a physician that they require an *antibiotic prior to dental treatment?* ❑ No If ❑ Yes, Antibiotic _____
  Method of administering antibiotic _____
- This patient's general health at this time is: ..... ❑ Good, ❑ Fair, ❑ Poor Comment? _____
- Is this patient presently under the care of a physician?..... ❑ No, If ❑ Yes, For What? _____
- Is this patient presently taking medications? ..... ❑ No, If ❑ Yes, What medications: _____
- Is this patient allergic to any medications (penicillin, etc)? ..... ❑ No, If ❑ Yes, Comment: _____
- Is this patient allergic to anything else? ..... ❑ No, If ❑ Yes, Comment: _____
- Are you now or have you ever taken medication for the treatment of osteoporosis? ..... ❑ No, If ❑ Yes, list medications: _____
- Has this patient had tonsils or adenoids removed? ..... ❑ No, If ❑ Yes, Tonsils (on date_____) Adenoids (on date_____) _____
- Does this patient have a *Chronic illness*?..... ❑ No, If ❑ Yes, Comment? _____
- Has this patient ever had a serious illness? ..... ❑ No, If ❑ Yes, Comment? _____
- Has this patient ever been *Hospitalized*? ..... ❑ No, If ❑ Yes, For what? _____
- **Does this patient now have, or ever had any of the following diseases?**

❑ No ❑ Yes Rheumatic Fever	❑ No ❑ Yes Hepatitis (type?_____)	❑ No ❑ Yes Diabetes
❑ No ❑ Yes Endocarditis	❑ No ❑ Yes Aids or HIV Positive	❑ No ❑ Yes Epilepsy
❑ No ❑ Yes Heart Condition	❑ No ❑ Yes Tuberculosis	❑ No ❑ Yes Stroke
❑ No ❑ Yes Heart Pacemaker	❑ No ❑ Yes Lived with person with tuberculosis	❑ No ❑ Yes Stomach Ulcers
❑ No ❑ Yes Heart Angina	❑ No ❑ Yes Respiratory Lung Disease	❑ No ❑ Yes Tonsillitis
❑ No ❑ Yes Heart Attack (coronary)	❑ No ❑ Yes Asthma	❑ No ❑ Yes Headaches
❑ No ❑ Yes Mitral Valve Prolapse	❑ No ❑ Yes Venereal Disease	❑ No ❑ Yes Earaches
❑ No ❑ Yes Congenital Heart Disease	❑ No ❑ Yes Herpes (Oral Cold Sores)	❑ No ❑ Yes Jaw Pain
❑ No ❑ Yes Artificial Heart Valve	❑ No ❑ Yes Inflammatory Rheumatism	❑ No ❑ Yes Jaw Clicking (noises)
❑ No ❑ Yes Heart Surgery (date:_____)	❑ No ❑ Yes Arthritis	❑ No ❑ Yes Metal Allergies (_____)
❑ No ❑ Yes Heart Murmur	❑ No ❑ Yes X-Ray (radiation) Cancer Therapy	❑ No ❑ Yes Allergies (_____)
❑ No ❑ Yes High Blood Pressure	❑ No ❑ Yes Glaucoma	❑ No ❑ Yes Drug Addiction
❑ No ❑ Yes Low Blood Pressure	❑ No ❑ Yes Fainting Spells	❑ No ❑ Yes Emotional Problems
❑ No ❑ Yes Blood Disorders/Bleeding Problems	❑ No ❑ Yes Kidney Trouble	❑ No ❑ Yes Psychiatric Treatment (date:_____)
❑ No ❑ Yes Anemia	❑ No ❑ Yes Liver Disease	❑ No ❑ Yes Prosthetic (Artificial) Joint

Comments on diseases checked off as Yes: _____

_____

- Does this patient have any other medical problems not listed?...❑ No, If ❑ Yes, Comment? _____

_____

Patient's Growth History:
(Growth spurts affect treatment)

What is this patient's height? _____Ft. _____In.
If a GIRL, has she started menstruation? ❑ No ❑ Yes
FATHER'S present height: _____Ft. _____In.
OLDEST BROTHER'S present height: _____Ft. _____In.

Have there been recent signs of increased growth? ❑ No ❑ Yes
If a BOY, has his voice changed? ❑ No ❑ Yes
MOTHER'S present height: _____Ft. _____In.
OLDEST SISTER'S present height: _____Ft. _____In.

Women Only:

Are you currently taking birth control medication? ❑ No ❑ Yes
Are you presently pregnant or considering pregnancy within the next two years? ❑ No If ❑ Yes, Comment: _____

_____

DENTAL HISTORY

Name of Family Dentist: _____ Date of last dental visit: _____

How many times a day do you ***BRUSH?*** ❑ 0 ❑ 1 ❑ 2 ❑ 3+ How many times a day do you ***FLOSS?*** ❑ 0 ❑ 1 ❑ 2+

- Has this patient been seen by another orthodontist? ❑ No, If ❑ Yes, Date: _____, Name of orthodontist _____
- Has this patient been treated for a "bad bite"? ❑ No, If ❑ Yes, Date: _____, Name of dentist _____
- Has this patient been treated for periodontal (gum) disease? ❑ No, If ❑ Yes, Date: _____, Name of dentist _____
- Has this patient been treated for TMJ problems? ❑ No, If ❑ Yes, Date: _____, Name of dentist _____
- Are there any other *Dental Specialists* who have treated you (Please give doctor's names, treatments and dates): _____

_____

- Does this patient have or been informed of any *Missing Permanent Teeth?* ❑ No, If ❑ Yes, Comment: _____
- Does this patient have or been informed of any *Extra Permanent Teeth?* ❑ No, If ❑ Yes, Comment: _____
- Does this patient have any *TMJ Symptoms (Jaw/Head pain, Noise, etc.)?* ❑ No, If ❑ Yes, Comment: _____
- Does this patient have any *Periodontal Symptoms (Bleeding gums, etc.)?* ❑ No, If ❑ Yes, Comment: _____
- Is this patient aware of any *sores, lumps or irritated tissue* in the mouth? ❑ No, If ❑ Yes, Comment: _____
- Has this patient had any *injuries* to his/her face, jaw, mouth or teeth? ❑ No, If ❑ Yes, Comment: _____
- Does this patient have any of the following habits? ❑ Thumb/Finger sucking ❑ Lip Biting ❑ Snoring ❑ Grinding of teeth @ night
  ❑ Mouth Breathing ❑ Other? ❑ NONE, Comments: _____

_____

- Does this patient have or been informed of any *Speech Problems?* ❑ No, If ❑ Yes, Comment: _____
- Is this patient anxious about having orthodontic treatment? ❑ No, If ❑ Yes, Comment: _____
- Is there anything this patient would like to change about his/her *Smile?* ❑ No, If ❑ Yes, Comment: _____
- What orthodontic problems need to be addressed for this patient? ❑ Appearance of teeth ❑ Function ❑ Crowding/Spacing
  ❑ Protrusion ❑ Other: _____

_____

- Any special reasons for this consultation not mentioned above? ❑ No, If ❑ Yes, Comment: _____
- Have any members of this patient's genetic family had orthodontic treatment?
  - *Mother:* ❑ No, If ❑ Yes, Dentist: _____ Were you satisfied with the results? ❑ Yes, ❑ No _____
  - *Father:* ❑ No, If ❑ Yes, Dentist: _____ Were you satisfied with the results? ❑ Yes, ❑ No _____
  - *Sister:* ❑ No, If ❑ Yes, Dentist: _____ Were you satisfied with the results? ❑ Yes, ❑ No _____
  - *Brother:* ❑ No, If ❑ Yes, Dentist: _____ Were you satisfied with the results? ❑ Yes, ❑ No _____
- Please list siblings living in the household:

  Name: _____ DOB: _____ Name: _____ DOB: _____

  Name: _____ DOB: _____ Name: _____ DOB: _____

I the undersigned have completed this medical and dental Health History Questionnaire and certify that the preceding information is true and correct. This practice cannot be held responsible for any problems arising out of inadequate information not disclosed here. If there are any future changes in this information, I will inform this practice of these changes.

Signature of person filling out this history: _____ Date completed/signed: _____

Signature of *TC* who reviewed this history: _____ Date reviewed/signed: _____

Signature of *doctor* who reviewed this history: _____ Date reviewed/signed: _____

Updates to this history:

Signature of *person* who *UPDATED* this history: _____ Date UPDATED: _____

Signature of *person* who *UPDATED* this history: _____ Date UPDATED: _____

Signature of *person* who *UPDATED* this history: _____ Date UPDATED: _____

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